



**NORTHWEST GROUP SERVICES**

Health Reimbursement Account  
**Claim for Reimbursement**

**Instructions**

1. Before completing this form, make sure your expenses qualify for reimbursement.
2. You must submit all covered health care expenses to the Insurance Carriers before submitting to your HRA
3. Complete this form as instructed below.
4. Mail this form with Explanation of Benefits (EOB's) to the address below.

**Personal Information** - Please correct any information which is not accurate.

HRA \_\_\_\_\_  
 Group Number                      Employer Name

\_\_\_\_\_  
 Social Security Number                      Your Last Name                      First Name                      M.I.

\_\_\_\_\_  
 Home Address

\_\_\_\_\_  
 City                      State                      Zip Code                      Daytime Phone Number (please add)

**Health Reimbursement Arrangement Expense Claims**

Date Expenses Occurred	Name of Service Provider	Expense Description	Name and Relationship of Person for Whom Expense Incurred	DEDUCTIBLE Amount

**Total Health Reimbursement Expenses Claim** reimbursement: \$ \_\_\_\_\_

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. I have not been reimbursed for these expenses nor are the expenses reimbursable under any other health and/or dependent care assistance plan. I am not applying these expenses toward any federal or state income tax deduction or credit.

Mail this form with receipts to:  
 N.W.G.S. (TPA Service)  
 2340 Detroit Ave. 2nd Floor  
 Maumee, Ohio 43537  
 Email: susanw@nwgsonline.com

**Your Signature** \_\_\_\_\_  
**Date** \_\_\_\_\_

**Questions: 1-888-808-3008**  
**Toledo Area: 1-419-887-1215**  
**Fax Number: 1-419-887-1214**